BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A Study of the Incidence of Mental Illness in Forty Siblings at the Metropolitan State Hospital

A Thesis

Submitted by

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(A.B., Wheaton College, 1945)

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TABLE OF CONTENTS

TABLE OF CONTENTS

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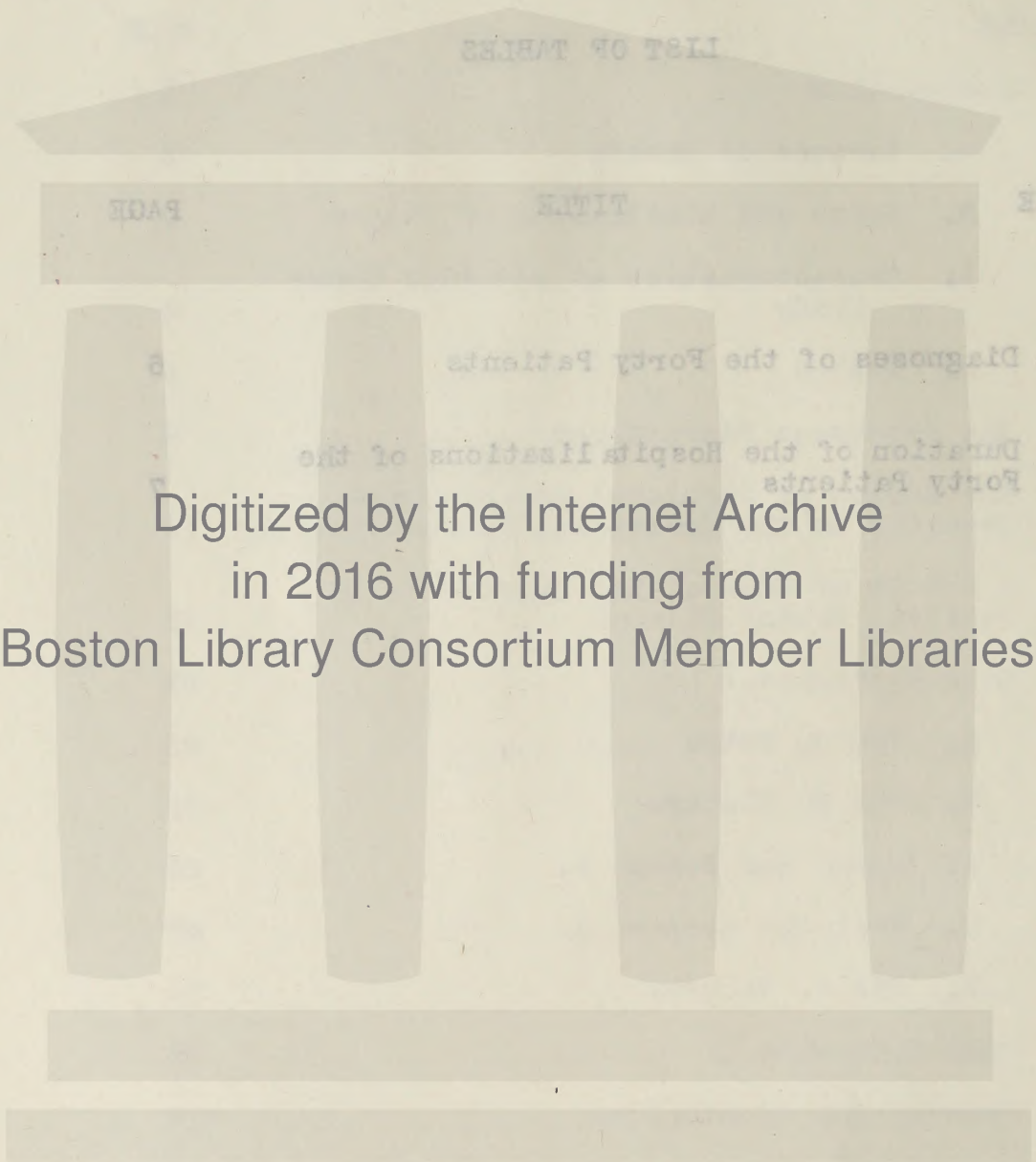
LIST OF TABLES



CHAPTER I

Introduction

Purpose of the Study. The purpose of this thesis is to study twenty pairs of siblings, under the age of fifty years at the time of the original onset of mental illness, who have been patients at the Metropolitan State Hospital in Waltham, Massachusetts. This study is to be made in the light of the siblings' family histories, of the environmental influences at work, and of the hospital courses of the individual members of the pairs of patients. The author wishes to study the presence or absence of economic and emotional stability in the individual patients as reflected by their home life while growing up and at the time of the onset of mental illness. Wherever possible, the emotional relationship between the two siblings prior to and during the illness of the first, and the successive interaction between the two will be brought out. An effort will be made to present a picture of the two siblings as they were prior to their illnesses, going back to their childhood briefly wherever possible. As clear a picture of the family group and the interaction within this group will be presented, based on the patients' hospital records and on interviews with the patients and their families. The author will try to stress the socialogical and minimize the

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psychological factors as much as possible, but will be limited in this somewhat by the material available in the case records. This is not intended to be a psychiatric presentation, that being left to medical men, but rather a psychiatric social worker's presentation of the available material on a specific topic, that of siblings seen at the Metropolitan State Hospital.

Scope and Limitations. This study included twenty pairs of siblings seen at the Metropolitan State Hospital over a period of sixteen years, from the time of the opening of the hospital to the present. As this hospital has been an admitting hospital only since April, 1943, the bulk of the earlier patients were transferred to it from other state hospitals, and thus the material in the case records is limited largely to that which was sent from these other hospitals. Of the forty cases under study here, twenty-one patients were admitted to the Metropolitan State Hospital prior to 1943, and of the nineteen remaining cases, five more were transferred from other hospitals. This leaves only fourteen of the forty cases as new admissions to the Metropolitan State Hospital, and consequently only fourteen cases on which there are up-to-date records. These newer records are likely to include the most complete family and personal histories on the patients and therefore are the ones from which the author would be able to glean the most valuable

information in the light of this study. Even the most recent case records have pitifully little material on the emotional life of the very young child, of his intimate relationships with his family group, and of his reactions to his early training and his mother's handling of this. All of these are vitally important to the child's emotional development, yet we are unable to obtain this information from even the most complete and well-done case records.

Of the forty patients under study, one was transferred to the Metropolitan State Hospital in 1930, and eleven in 1931. The records of these patients are sadly lacking in current data and conclusions must be drawn from the available material and from the reports of the hospital personnel who have been most cooperative in this matter. Little can be learned from the patients themselves in such cases as many of them have deteriorated to a point where their statements can seldom be held as valid. Similarly, in such cases, there are seldom relatives who have kept in touch with the patient or who remember adequately the information desired for this type of a study.

Despite all these drawbacks, however, one is able to glean much from the case records through such factual data as the age of the patient at the time of the onset of mental illness, the proximity in the ages of the two siblings, the

family history, the social and economic status of the family and the individual, the similarity of the illnesses, the duration of the illnesses, and the possible interaction between the two patients in the hospital setting. All of these data help to throw light on the topic under study.

Characteristics of the Patients Under Study. The patients included in this study are divided as follows: nine pairs of sisters, four pairs of brothers, and seven mixed pairs. The ages at the time of the first onset of mental illness vary from eleven to forty-nine years of age. The diagnoses include, dementia praecox of all five types, manic depressive psychosis of the manic type, paranoia and paranoid conditions, involutional psychosis - paranoid, psychosis with epidemic encephalitis, and psychosis with mental deficiency - moron. The duration of the mental illnesses varies from two months to thirty-three years, including both those patients who have been ill and have recovered and those who are still hospitalized. (see Tables I and II.)

Method. The method of study has varied with the individual under study at the moment. Fundamentally, the findings and deductions have been based on the case records of the particular patients. This material has been supplemented with interviews with those patients who are still in

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the Metropolitan State Hospital and who are well enough to be interviewed personally. In most cases, and especially those in which the case record material is scant, the hospital personnel has been consulted in order to help clarify obscure points. In the case of those patients who have gone out of the hospital on indefinite visit, the Social Service reports of home visits and also the notes made by the doctors at the time of the patients' visits to the hospital during the year of their indefinite visits have been utilized. In the case of three pairs of siblings, the author has had one of the pair under Social Service supervision and has thus been able to get first-hand the emotional interaction between the two siblings from the patient.

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TABLE I.

DIAGNOSES OF THE FORTY PATIENTS

Diagnosis	No. of Patients		
	Total	Male	Female
Dementia Praecox	33	13	20
Simple Type	1	1	0
Paranoid Type	7	4	3
Hebephrenic Type	5	0	5
Catatonic Type	16	7	9
Type Undetermined	4	1	3
Manic Depressive	2	0	2
Manic Type	2	0	2
Paranoia and Paranoid Conditions	1	0	1
Involutional Psychosis, Paranoid	1	0	1
Psychosis with Epidemic Encephalitis	1	0	1
Psychosis with Mental Deficiency, Moron	2	2	0

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Psychosis with Epidemic Encephalitis	1	0	1
Psychosis with Mental Deficiency, Moron	3	3	0

TABLE II

DURATION OF HOSPITALIZATION OF THE FORTY PATIENTS

No. of Years	No. of Patients
Less than 1	6
1 - 2	6
2 - 3	5
0 - 5	17
5 - 10	4
10 - 15	6
15 - 20	5
20 - 25	3
25 - 30	4
30 - 35	1

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No. of Years	No. of Patients
Less than 1	6
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2 - 3	5
0 - 5	17
5 - 10	4
10 - 15	6
15 - 20	5
20 - 25	3
25 - 30	4
30 - 35	1

CHAPTER II

The Psychoses Encountered

Historically, changes have taken place in the classification of mental illness. Kraepelin was the first to divide the functional psychoses into the two major groups of manic depressive psychosis and dementia praecox. "He described manic depressive psychosis as a condition characterized by long periods of either elation or depression or the alternation of both, with long free periods between. These attacks might occur throughout a person's life and never lead to dementia (intellectual deterioration). Dementia praecox he described as a condition which appears at an early age - the end of the second decade or the beginning of the third - and, with various symptoms, (e.g., characteristic delusions and hallucinations) continues through life, resulting in a progressive mental deterioration."[1]

Later Bleuler observed that symptoms of dementia praecox may appear later in life and that patients may recover and be able to function normally in their social and wage-earning lives. "The most important element in the psychopathology was considered a characteristic disturbance

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of the patient's emotional life, a 'splitting of the personality', which was why Bleuler called this disease schizophrenia rather than dementia praecox. This 'splitting' refers to the incongruity in thoughts, emotional reactions, and behavior, whereby a patient may state, with apparent emotional indifference, that he is a king and a moment later agree to scrub a floor."[2]

The third main type of psychosis is the organic in which case the individual has a serious bodily condition which is caused by physical agents. Plus this physical condition there is a psychological reaction to these organic difficulties. To the layman the most well-known of these is called psychosis with cerebral arteriosclerosis. The physical agent is the hardening of the arteries, and through this the impairment of mental functions. Psychologically one sees an individual with increased irritability and with the loss or impairment of memory. The type of organic brain disease to be found in this paper is that of epidemic encephalitis with its resulting psychosis. There will be a discussion of this psychosis in a later part of this chapter.

Let us turn now to a closer examination of the psychoses encountered in the forty cases under study in this

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thesis. Those individuals with schizophrenic reactions or those for whom the diagnosis has been dementia praecox, form the greater part of the cases studied. There are thirty-three of the forty patients with this diagnosis. The general symptoms of this type of psychosis may be described briefly as: 1) an emotional dulling; 2) bizarre thinking; 3) delusions, preoccupation with curious inventions, plans, and mechanical devices; 4) frequent obscene hallucinations; 5) rigid behavior with a silly fixed smile, stereotyped movements, negativism, or automaton-like behavior; and 6) radical alteration of speech, including the coining of new words, rambling, monosyllables, and nonsensical utterances.

There are several types of dementia praecox: 1) Simple, 2) paranoid, 3) catatonic, 4) hebephrenic, and 5) mixed or type undetermined. The simple is characterized by apathy and disinterest. The paranoid's dominant symptoms are ideas of reference and incluence, delusions of persecution, and often delusions of grandeur. The catatonic reaction may be precededby simple or paranoid reactions, but in some cases it is present almost from the beginning. There is usually a fluctuation between depression, excitement, and stupor. The hebephrenic displays queer impulsive conduct, weeps and laughs suddenly and without provocation, and has lively hallucinations. This type is generally more incoherent in thought than the other types of dementia praecox. As a

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rule, the hebephrenic type is also characterized by a considerable degree of silliness. Lastly, the mixed or type undetermined refers to those cases of dementia praecox in which there is no clear differentiation of symptoms into one of the above-mentioned categories. In this paper, the term dementia praecox will be used rather than schizophrenia as it is the one used in the records of the Massachusetts Department of Mental Health.

Klein has said that "the psychiatrist, as he deals with these (mental) conditions in his practice, feels that dementia praecox is, so to speak, deeply embedded in the nature of the individual, (and) that there is a sort of fatalistic destiny operating".[3] Landis and Page back this statement by saying that "schizophrenics are constitutionally predisposed to mental illness".[4]

The second main type of psychosis is the manic depressive psychosis. Generally the following may be said of this disease: 1) some patients have periods of depression only, some periods of elation only, and others have an alternation between the two; 2) the illness may develop suddenly or gradually, and may terminate in the same way; 3) there are

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3 D. B. Klein, Mental Hygiene, the Psychology of Personal Adjustment, p. 152.

4 C. Landis, and J. D. Page, Modern Society and Mental Disease, p. 145.

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usually periods of several years between attacks during which the patient is essentially "normal" in his personality and behavior; 4) the attacks often recur; and 5) the attacks do not lead to deterioration as is frequently the case with patients suffering from dementia praecox. The intellectual and emotional faculties of the manic depressive patients, then, remain preserved. The characteristics of the manic phase are: 1) elation or the feeling of happiness and well-being; 2) flight of ideas or the jumping from topic to topic without continuity of thought; and 3) a great increase in the psychomotor activity of the individual. The characteristics of the depressive phase, on the other hand, are logically found at the other extreme being as follows: 1) intense dependence on another individual; 2) strong hostility toward this individual which the patient turns on himself; 3) intense self-condemnation, guilt, feeling of worthlessness, and expectation of disapproval and abandonment because of this hostility. In the case of the mixed types of the manic depressive psychosis the patient fluctuates between these two types and may at different times show symptoms of either type.

To turn now to the less common minor types of psychosis we must now consider first the involutional psychosis, paranoid type, and paranoia and paranoid conditions. The former is most commonly found in women passing through or just

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following menopause. This condition is brought on by a combination of the physiological changes occuring combined with the psychological factors revolving around the cessation of sexual potency. The major symptoms of this disease are depression and irritability, frequently coupled with a considerable degree of agitation and anxiety. Mental retardation seldom is a result of this type of mental illness. Usually, the women who have this type of illness have never before been mentally ill. Recovery usually follows after a fairly short period of time with little therapy being administered outside of the general psychotherapy of any mental hospital.

In the case of paranoia and paranoid conditions we first notice a period of depression during which the patient is hypochondrical, preoccupied with physical sensations, and inclined to brood. An attitude of bitterness and resentment becomes accentuated and a stage of persecution sets in. Suspicion is constant, and misinterpretation leads the patient to see evidences of hostility. Unfortunately, there is not always so much hope for a quick recovery in this case as there is for the patients with involutional psychosis, although recoveries do occur.

To turn now to the organic psychoses, only the two found in this study will be discussed, psychosis with epidemic encephalitis and psychosis with mental deficiency,

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Lastly, we will touch on the question of feeblemindedness. This is a condition in which the intellectual capacities of the individual are limited for one of several reasons. The condition may be present from birth and may be a result of birth injury or heredity. The person may have suffered some trauma or shock, or may have had some disease which left him with an impaired intellect. There are three main divisions of the feebleminded: the idiot, the imbecile, and the moron. The last-mentioned is the

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highest group in intellect and comes the nearest to the "normal". The two cases ofpsychosis with mental deficiency in this thesis both fall into the moron group of feeble-mindedness. As the moron who was born with his limited mental grows up he frequently requires care and supervision to protect both himself and society. He often requires the specialized instruction of special classes of the schools for the feebleminded as he is not always able to benefit from the more competative instruction of public schools. His personal appearance is essentially the same as that of the "normal" individual although he may pay less attention to his dress and behavior. His face may characteristically carry a so-called "stupid" or dull expression. The moron frequently finds it difficult to survive in a highly competative social system and often can make an easier and more adequate adjustment in a rural community. As a rule, the moron can adjust quite well to a farm routine, although there are exceptions to this. When such individuals develop a psychosis and are seen in the state hospitals, they are often diagnosed simply as psychosis with mental deficiency, moron. The psychosis itself is seldom defined as to type, although it frequently resembles strongly dementia praecox. The deterioration is not always evident at first as the individual is fundamentally dull, but as the illness progresses the mental decline becomes more apparent.

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The author has endeavored in this chapter to present a picture of the types of mental illness encountered in the forty patients under study in this thesis, minimizing those generalities which would not throw light on the patients to be discussed in later chapters.

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CHAPTER III

The Effect of Emotional and Economic Security on the Individual Psychologically.

An infant comes into the world with three primary emotions: love or happiness, anger or rage, and fear. From the start he seeks the first of these, and when he obtains it he also obtains security. To the infant security comes in the form of warmth, dryness, food, and fondling. At first, the mother is the total environment to the infant, and he cries for her to come and comfort him. As the child grows up his world becomes a widening circle to include his father, siblings, and visitors to the home. His security also comes from a wider range of sources as he grows up. He gains security from seeing his parents living together happily and without serious or continual conflict. He gains it from living in a warm house, a house in which he knows he can always get sufficient food to keep him from going hungry. He gains security from looking, dressing, and doing like the other children in his neighborhood, and from seeing his parents conform to the neighborhood standards. Lastly, and also vitally important, he gains security from receiving warmth and understanding from his parents, who for a number of years represent the adult world to his young mind. A child without these makings of security may be a fearful child

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and as a result of this fear may become belligerent in an effort to hide his fears from the rest of the world and even from himself. Through this belligerent behavior he may even go to such extremes that society will label him as anti-social or a-social.

The adult varies little from the child in his concept of security, except that his circle is widened and he desires, even more than the child, the respect and approval of his fellow men. He wants a steady income, a place in which to live, money enough to buy food and clothing and much needed recreation, and the love and devotion of his family. If he is married he wants also the love and respect of his children. Without this security the adult acts in a manner very similar to that of the child. He, too, may try to cover up his fears by becoming hostile. But he may also worry and brood over what is actually his lack of security (although he may think of it in many ways and under many other names), and through this mental strain may become mentally ill and require hospitalization. Even the person who has never known real security may eventually break under its lack.

In this paper we will see forty individuals, mostly from urban communities, and many of marginal economic status. The urban community in itself is almost synonymous with a high degree of competition. This competition in turn is a

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continual threat to the individual's security. The individual must always be on his toes to keep his job and/or to get ahead in the work he has chosen. He has the rent to pay; the food and clothing to buy; he desires possessions which, especially in the city, help him gain status; he wants and needs some recreation, which in the city is seldom free to him; and he needs money for countless other items which he needs and desires. He may well become fearful of illness which would prevent him from working and earning money for all of these needs. He may also worry about losing his so recently gained security, and this fear may in turn cause him to do a poorer piece of work, which in itself is a stronger threat to his security. Thus, a truly vicious circle is created.

When one considers individuals of marginal economic status it is possible to see very clearly the working of this circle. These individuals already are uncertain of their next meal or of meeting the rent and clothing bills. They wonder if they can hold their job, and if their work will cover the numberable bills they have to meet. Should illness strike, where could they turn? Would it mean long hours of waiting in the free hospital clinics? Or would it mean death? Such a type of existence is not conducive to security of any form, and many are unable to stand the continual strain of wondering and worrying. There are many

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CHAPTER IV

A Review of some of the Literature on Familial Mental Illness.

Studies of familial mental illness have shown that among siblings there is usually a similarity in the outstanding symptoms of the illnesses, although the actual diagnoses may differ. When one sibling has dementia praecox, the other sibling may be mentally defective. When one sibling is diagnosed as dementia praecox and the other as manic depressive psychosis, the former frequently has manic coloring to his symptoms. Many psychiatrists feel that similarity between the illnesses of the two siblings is the rule, and at times several have equestioned the possibility of incorrect diagnoses in one of the cases when dissimilarity is present.

L. A. Osborn made a very interesting study of a family with a positive family history.[1] There was a history of tuberculosis in the family, the father was eccentric and alcoholic, and the mother had spells of depression with each pregnancy which were diagnosed as mild melancholia. There were nine siblings in this family, five of whom were psychotic.

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The first sibling was not psychotic and died of gastric cancer. The second had "subacute mania" and died of tuberculosis. The third had two spisodes of manic depressive psychosis, both of the manic type. The fourth was mentally defective and had two children in the state schools for the feebleminded. The fifth was admitted to a state hospital at twenty-six years of age and had recurrent episodes. She was diagnosed as "acute melancholia" and died of tuberculosis and "cerebral thrombosis". The sixth was hit on the head by an insane uncle at the age of thirteen and at twenty-one was admitted to a state hospital and diagnosed as dementia praecox - paranoid type. She died of tuberculosis. The seventh suffered from thyroid. She had fourteen hospital admissions and was manic depressive with manic phases, depressive phases, and mixed phases. Three of her five children were either mentally defective or suffered from mental illness. The eihhth was mentally well, but of her three children one was born dead and another died of heart trouble. The ninth was nervous but not mentally ill. She had two children, a son who was mentally well and a daughter who suffered from dementia praecox - catatonic type. The author went on to say that these siblings had a strong element of suggestibility and fear when mental illness struck the family. One must also consider the family history of tuberculosis and perhaps mental retardation

as non-genetic factors. A later note stated that although there were three siblings with dementia praecox and two with manic depressive psychosis, the latter two demonstrated many symptoms similar to dementia praecox. He also stated that psychotic people tend to unbalance others, a theory with Kempf called "psychic contagion".

Bleuler and Brill have observed that in families where there is mental illness, those members who are not actually ill themselves, often display certain deviations in their personalities which run in the direction of the mental illness.[2] This deviation, of course, may occasionally develop into a neurosis or actual psychosis after a long period, depending on the strength of the various influences. Levine states that there is a popular misconception that heredity is the chief cause of psychiatric disorders, and that the individual who believes this can actually lead himself to severe anxiety and psychiatric symptoms.[3] Thus, many individuals can actually bring about a psychosis when they might never have needed to have become mentally ill.

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Lastly, let us turn to Dr. Abraham Myerson whose latest study, "Family Mental Disease in Private Practice", has just been published.[4] In this paper the author studied only parents and siblings, and pairs of siblings, both of whom were known to him through his private practice, or one of whom he knew while the other was known to some state hospital. In the latter instance he obtained the case history from the hospitals. In this paper he noted that twenty-three per cent of his schizophrenic patients had a family history of personality disorder. Of the siblings he noted that twenty-one patients had similar diseases while eight had dissimilar diseases. In the case of depressive states, there were forty-one siblings, twenty-three of whom had similar, and twenty-one of whom had dissimilar diseases. In the depressive states there were observed to be a very high incidence of family disease, although in the case of dementia praecox this was felt to be less highly true. In explaining this latter observation, the author felt that constitutional, if not hereditary, factors should be considered.

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CHAPTER V

Case Histories I

The first case to be presented is that of the G twins, Tim and Tom. The author has been particularly interested in this case because she had the surviving twin, Tom, under Social Service supervision while he was home on indefinite visit. Thus, it was possible to obtain first-hand the emotional interaction between Tim and Tom. It was also possible to discuss the twins with their mother and with a younger brother who was very cooperative in furnishing helpful information. Both of these boys were mentally ill recently so that their records are two of the most complete in the light of this study of any read by the author.

The father of these boys was born in Ireland in 1885. His parents had both died there of old age. The father came to this country and became a citizen in 1911. He was employed, until shortly before his death, as a semi-skilled worker in a large well-known factory near his home. Physically he had a history of asthmatic attacks which were felt to have been associated with a coronary condition, and he also suffered from rheumatic arthritis and kidney trouble. The twins' mother was also born in Ireland, in 1889. Her mother had died young of tuberculosis and her father had

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died of old age. The mother came to this country with the father and became a United States citizen in 1916. Her health has been described as good until recently when she had several minor illnesses. The twins are two of four brothers in the family, there being one brother a year older who served in the Navy for forty-nine months, being stationed in the South Pacific, and another brother two years younger who served in the Army for thirty-nine months. The family is Catholic by religion and lives in an urban section. Their income has been described as marginal. There is no known history of mental or nervous disorder of any kind in the family aside from that of the twins whom we are about to study.

The twins were born March 29, 1919, and were delivered by means of instruments. They were considered to be normal, healthy infants, and from the time they were born they became the center of parental attention, the mother, in particular, always taking care to direct the twins' actions and thinking. Tim, the first of the twins, was the stronger of the two from birth, and it was a family joke that even while they were still in the crib, Tim would take over Tom's bottle after finishing his own. On leaving the crib, Tim walked and talked just ahead of Tom, although both were said to have acquired these abilities earlier than many infants.

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Both had mumps, measles, whooping cough, and chicken pox, and at the age of six years, Tom had a tonsillectomy, The two boys were very similar in their appearance and played together continuously until their teens. As the boys came from a very devout Catholic family, both served for awhile as altar boys in the church. As they grew up, however, Tom was seen to be more conscientious than Tim about fulfilling his religious obligations.

When the boys reached their teens, they continued to resemble each other in personal appearance, but their personalities were seen to differ. Tim continued to be the stronger and became the leader while Tom became almost seclusive in his behavior. Tim began seeking the company of the opposite sex, while Tom preferred male companions. Neither of the boys received any sex instruction in the home, and as Tom remained relatively dependent on his mother for instructions and advice, he went without, while Tim went elsewhere for his information. Scholastically both boys were good students and both completed their high school courses. Tim was a slightly better student than Tom and was usually on the honor roll. After high school he went on to a post graduate course in commercial subjects and later to a business school. Throughout the twins' school career, as in everything else they did, the mother played one against the other in a continual form of competition.

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At this time, Tim proved to be the model.

In 1930, when the twins were eleven years old, Tim received a slight concussion as a result of an automobile accident, and was unconscious following this for a brief period. Shortly afterwards he had a mild nervous breakdown during which he became sleepless and had a loss of appetite. This illness occurred at a time when the twins were in the habit of playing together a good deal, and as is often the case with siblings, particularly with twins, the incident made a deep impression on Tom.

In 1937, when Tom was eighteen years old, he left home and joined the CCC movement, and was stationed in Vermont. While there he entered into his first heterosexual relationship, and after a brief acquaintance with the girl, and with his limited knowledge of sex, he impregnated her. Tom was very much frightened by this turn of affairs and, being naturally seclusive and inclined to brood, he kept the incident to himself. After a short time, he was sent home, without explanation, as mentally ill. The rigidity of the home permitted him no confidant and he brooded to a point where it was necessary for him to undergo a period of observation at the Boston Psychopathic Hospital. He was discharged after a few days, without diagnosis, to the Glenside Hospital from which he was discharged with a diagnosis of Dementia

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About a year after this episode, in 1940, when the twins were twenty-one, Tim joined the CCC movement. He remained in this service for four months, at the end of which time he was returned home in an excited, noisy, and run-down state. He was observed at the Boston Psychopathic Hospital and wad diagnosed as manic depressive psychosis - manic type, and was transferred to the Foxboro State Hospital for sixteen months with the same diagnosis.

During the ensuing period the twins were classified as 4F on the basis of their previous episodes of mental illness. Although both boys were sensitive about this classification, especially as they were healthy-looking young men and their brothers were both in service, Tim proved even more distressed at being reminded of it and teased about it than Tom. To add to Tim's worries, he was keeping company with a girl whom he intended to marry, but she, too, had no understanding of his 4F classification and continually questioned him about this. She finally broke off their engagement and joined the WAVES, taking care to notify Tim later that she had married a serviceman. This,

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of course, disturbed Tim and he started going out with almost any girl he met. Following this, he renewed his interest in school work and started attending a business school. He was employed during this period in a number of restaurants as a dishwasher and waiter, but failed to keep any of these positions for any length of time. Finally in 1944, when he was twenty-five years old, he became disturbed, left his job, and came home crying to his mother that he could not meet people and that he did not want to work. He refused to leave the house without his mother, became sleepless, and lost his appetite. During the following year he became touchy and resentful of family criticism, and even more jealous of Tom whom the mother held up to him as an example of good post-hospital adjustment. Tim then began to drink heavily and started spending all of his own money (his earnings plus that from his bank account) and a considerable amount borrowed from his mother but never repaid. This money went for drink and for entertaining a number of different women with whom he was associating. He kept late hours continually although he had to go to work early in the morning. His daily routine became going into a bar as soon as he finished working and staying until supper time. He would then go home long enough to eat and then would return to the drinking until the early hours of the morning. During this period he developed mood swings and was inconsistent about his personal

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appearance. When not depressed and irritable he would become unnaturally happy and would laugh, joke, and tease his family unmercifully. On the morning of his final admission he was said to have gone through the house like a whirlwind and was destructive and noisy. He had an odd expression on his face and grimaced as if there were someone walking next to him. Tom was sent after him when he left the house, and when he tried to bring Tim back to the house, the latter struck him. Tom then called the police who took Tim to the Danvers State Hospital.

Tim was admitted to the hospital on October 16, 1945, at twenty-six years of age. He was cheerful but very disturbed. Later he required seclusion and pack treatment. He then developed a fever and after this condition subsided he became stuporous and died shortly thereafter of Septicemia, probably caused by hypodermic injection. His diagnosis this time was changed to dementia praecox - catatonic type.

The day following Tim's death, Tom became depressed and expressed the belief that what happens to one twin must also happen to the other. He became preoccupied, stopped working, and engaged in peculiar behavior. He also developed nocturnal enuresis. He refused to take medicine which was prescribed for him by his doctor, and refused to eat or drink.

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He became easily irritated at the other members of the family, and was especially annoyed at his older brother's excessive drinking, possibly because he could not keep up with this brother. This in itself might have had a lot to do with renewing his old feeling of inferiority to this brother. Five weeks after the death of Tim, Tom was admitted to the Metropolitan State Hospital and was diagnosed as dementia praecox - type undetermined. He was evasive on admission and denied hallucinations and delusions although they were very active. He was irritated at what he felt to be his family's over-solicitous attitude, and was very sarcastic. Seven months later he had improved sufficiently to be released from the hospital on indefinite visit. During this visit his father died following a relatively brief illness, but by that time Tom had regained his self-confidence sufficiently to ward off an additional attack of mental illness, and when last seen was doing very well in the community.

It is interesting to note in this case that although the two boys were very similar in appearance, as adults, Tim was socially-minded and tended to associate with the opposite sex while Tom was seclusive and retiring and preferred male companions. Also, when one of the boys was ill the other was always well so that they tended to help each other along through the early, pre-hospital stages of their

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illnesses. As is frequently the case with twins, despite personality differences, these boys identified strongly with one another and had the feeling that what happened to one would surely happen to the other. Thus, when one became ill, the other felt that sooner or later he, too, would be similarly afflicted. Both boys tended to brood over this belief. Although Tom's diagnosis was consistently dementia praecox - type undetermined, and Tim's diagnosis was twice manic depressive psychosis - manic type, it is interesting to note, especially in the light of the literature reviewed in Chapter IV, that Tim's final diagnosis was dementia praecox - catatonic type. Both boys were inclined to brood in the early stages of their illnesses and to run away from their jobs, returning to their home and to their mother. It was as if they had never been able to emancipate themselves from their mother who was an extremely domineering and over-protective woman. Even when they considered leaving the house during the early stages of their illnesses, they needed their mother's companionship on such excursions. Apparently they both felt that she alone could comfort them satisfactorily, although they did regularly turn to each other. Despite the influence of their mother, however, it was in each case necessary to resort to hospitalization. The hospital courses of the two boys were also very similar, and their ages at the time of onset ran along together quite

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It can be seen that the twins identified strongly with one another and influenced each other's succeeding illnessto quite a degree. It is interesting to see also that although their personalities differed a good deal, they stuck together as against their brothers, and during the war as against almost everyone else. This latter period, in particular, was, of course, influenced largely by the boys' 4F classification.

The second case to be presented is that of two sisters, Agnes and Elizabeth G. Nothing is known of the parents of these sisters aside from the fact that their mother died in 1911 and that the family history is believed to be negative in regards mental or nervous illness. The first sister, Elizabeth, was born in 1889 and went through high and normal schools. As a child she had a spinal injury but nothing further is known of her younger years. On leaving school she worked as a bookkeeper and stenographer for six years and then as a collector for a transportation company for three years. Following her mother's death, when she was twenty-two years of age, she remained at home and cared for

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The second case to be presented is that of two sisters, Agnes and Elizabeth G. Nothing is known of the parents of these sisters aside from the fact that their mother died in 1911 and that the family history is believed to be negative in regards mental or nervous illness. The first sister, Elizabeth, was born in 1889 and went through high and normal schools. As a child she had a spinal injury but nothing further is known of her younger years. On leaving school she worked as a bookkeeper and stenographer for six years and then as a collector for a transportation company for three years. Following her mother's death, when she was twenty-two years of age, she remained at home and cared for

the house. The second sister, Agnes, was born in 1892, being three years younger than Elizabeth. She was nineteen at the time her mother died. Agnes left school at the age of sixteen and went to work for the same company as her sister. She remained there for a period of about eighteen years, stopping only when she became mentally ill.

Following the death of their mother, the two sisters eventually went to live with their brother who was a bachelor. Elizabeth cared for the house while Agnes continued to work. About 1919, when she was thirty years old, a gradual change was noticed in Elizabeth. She started reading books on psychoanalysis, took to free thought, and became careless about her personal appearance. She ceased going to church although she had formerly been very regular in her church attendance. She began smoking excessively, her housekeeping became haphazard, and although she did not appear to be hallucinated, she had fits of temper with increasing frequency and severity. She domineered her sister and dictated Agnes' every move. Meanwhile, by 1924, when Agnes was about thirty-two years old, her behavior also was observed to be changing. She became depressed and had ideas of self-degredation, resulting from some real or fancied misconduct with a man. She was deluded but refused to talk about her ideas. She gradually became less active, refused

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to work, acquired the habit of smoking, and began neglecting her personal appearance.

In May, 1926, when Elizabeth was thirty-seven and Agnes was thirty-four years old, their brother died and it was felt by their two married sisters that they were completely unable to care for themselves. Two weeks following their brother's death, then, they were both sent to the Boston Psychopathic Hospital for observation. They were then transferred to the Westboro State Hospital where they remained for almost five years, at which time they were transferred to the Metropolitan State Hospital where they have been for almost sixteen years.

On admission Elizabeth was rather dull in appearance but cooperative. She appeared deteriorated, and although she had no hallucinations, she was emotionally very dulled. At no time since her original admission for observation, has she showed any indication that she realizes that her sister has gone through an identical series of hospitalizations, although they frequently have resided on the same wards and have worked in the same shops in the various hospitals. Elizabeth has been seclusive, indifferent, and apathetic. At times she has periods when she is destructive, alternating with periods when she is over-solicitous of her personal appearance. During these latter periods she

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will remove her clothing several times a day and wash thoroughly. She has followed this pattern throughout her hospital stay and continues to become more and more deteriorated both intellectually and emotionally.

Agnes, on the other hand, was felt at the time of admission to have been able to adjust to her surroundings fairly well while in her brother's home, but that Elizabeth's continual pathological influence had finally brought about a change in her personality to a point where she, too, became mentally ill. She was cooperative and quiet on admission, but emotionally flattened. Although she has remained essentially tidy in her personal habits, she has seldom been occupied for any length of time while in the hospitals, apparently preferring to remain detached from her surroundings and generally seclusive. Both sisters have had brief periods when they could be convinced to do small tasks about the hospitals, and although they both did their work well they did it in automaton-like fashion. Also like Elizabeth, Agnes shows no interest in her sister and they seldom have anything to do with each other. Agnes, too, is generally quiet and indifferent. She speaks to no one but her sister, and seldom does even this. She periodically becomes disturbed for brief periods, but on the whole is quiet. Like her sister, she appears deteriorated both

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These two sisters have been together ever since they were born, at first in their parents' home, then in their brother's home, and for the past twenty-one years in state hospitals. Prior to their illnesses, they both worked together briefly in the same place of employment, although Elizabeth left after their mother's death to care for the home. They have always been close emotionally, up to the time of the onset of Elizabeth's illness, neither having married. Agnes then became domineered by Elizabeth and gradually, after about five years of being under her influence, developed mental symptoms herself. Their appearance and mental conditions are very similar as are their hospital courses and diagnoses, both having been diagnosed as dementia praecox - hebephrenic type. They both have deteriorated considerably both emotionally and intellectually, and their behavior patterns follow similar lines. Both are seclusive and although they no longer show any interest in one another, they will speak to no one else in the hospital.

The third case is that of a brother and sister of Italian parentage, Agnes and Joseph F. The father was born in Italy about 1870 and came to this country twenty years later. Except for one trip back to the Old Country,

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The third case is that of a brother and sister of Italian parentage, Agnes and Joseph R. The father was born in Italy about 1870 and came to this country twenty years later. Except for one trip back to the Old Country,

he has lived here since then. His health has been described as only fair as he has rheumatism of both the arms and the legs. He has been described generally as having a pleasant disposition and a keen interest in his family. Despite this observation, however, it has been reported that he beat his children with a strap on numerous occasions as a form of punishment. The mother was also born in Italy, about 1860, and came to this country with the father. She is reported to be in good health, still doing her own housework at sixty years of age. Her personality, however, has been said to be one of irritability. There are four siblings in this family: a married sister who is of normal intelligence and who is emotionally stable, Joseph and Agnes wo will be discussed in this presentation, and a younger brother who is mentally well.

The first patient, Joseph, was born in this country in 1910. His birth and early development were normal. At the age of two he went to Italy with his family and stayed there until he was nine years old. He went to the second grade there and on returning to this country, he started over in the first grade. He went as far as the fifth grade and left school at about thirteen years of age to go to work. He had a very good record in school, and continued to receive good reports on going to work. He took any job that offered itself and was quite ambitious about working.

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He liked to drink occasionally but never did so to excess. He was quiet and although he never displayed any interest in girls, he did enjoy company and liked to have a good time. In 1928, when he was eighteen years old, some friends took him to Canada to get a job, but left him there alone while they returned to this country. He was generally a pleasant person, but this incident disturbed him and he became a bit "hot-headed" over it. He enjoyed both watching and participating in sports and trained for a while as a fighter. He habitually ran about eight miles to work every morning. His health was always excellent. He was a very devout member of the Catholic faith.

The second patient, Agnes, was born in Italy in 1912, and was also normal in her birth and early development. She also completed two years of school in Italy and on returning to this country started over in the first grade. She completed the ninth grade at about sixteen years of age and then quit because the children poked fun at her marked tremors. Up until the age of twelve years, she was a very active, pleasant child. She had many playmates and never demanded attention. When about twelve years old, in 1924, she went to a shore resort and went in swimming while menstruating and directly afterwards became overly excited while riding a roller coaster. On arriving home she had a fever and a tremor of

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the right arm and leg. She was confined to bed for thirty-six hours and following this, the tremors persisted and got worse. Since that time Agnes had little social life because of her physical condition, but her family did not feel that there was any change in her personality. She was never employed outside of the home, and her home life was never a particularly happy one. In 1927, when she was fifteen, she was referred to the nerve clinic at the Massachusetts General Hospital, at which time she was observed to be irritable, impudent, and emotionally unstable in that she cried easily. It was learned from her at that time that her father frequently beat her with a strap. Her IQ was found to be sixty-two and it was thought that she showed signs of post-encephalitis. There were no psychotic symptoms present, however. The following month she was referred to the Massachusetts Society for the Prevention of Cruelty to Children as both parents were beating her severely. There was found to be much friction in the home over Agnes' condition and the parents expressed a desire for her to be cared for elsewhere. In the society's Temporary Home, Agnes was unmanageable, cursed a great deal, threatened suicide, and in general was felt to be an institutional case. At the Massachusetts General Hospital, when seen again, she was diagnosed as hysteria plus mental deficienty, and was referred to a child-placing agency. In the foster homes she

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was very much disturbed by the agency's visitors and requested that they cease coming unless both of her parents were very sick. She was dirty and unkempt, and the foster mothers complained that she was stubborn and showed a strong temper. She went into the seventh grade on trial and failed all subjects except writing and sewing. In November of 1928, when she was sixteen, she was sent to the Out-Patient Department of the Peter Bent Brigham Hospital where she was found to have right hemiparesis. Shortly afterwards she was readmitted to the Massachusetts General Hospital, complaining of nervousness, and the diagnosis of post-encephaltis was upheld, with the addition of Parkinsonian Syndrome.

During all this time, Joseph continued to go from job to job until finally one morning in 1933 he went to Holy Communion at church and became ill. On returning home he fell several times, rolled over and screeched that he wanted a priest to pray for him. He refused to be touched. As Agnes was home during this attack she was sent to get a priest. After the priest had finished praying over Joseph, the attack stopped and he said that he felt all right. He then began to feel that the men where he worked were jealous of him and had given him something to make him ill. After this he had several more attacks, but in none of them did he lose consciousness. As his ideas advanced, he began

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to feel that the men at the shop owed him some money so he sent Agnes to collect it. When she returned without any money he turned against her saying that she was keeping it from him. He then started going to church with increased frequency, and said that during his prayers he could hear voices talking to and about him. He became very frightened by his auditory and visual hallucinations, and talked a great deal about them.

When he was twenty-three he was admitted to the Danvers State Hospital where he was at first very evasive, depressed, and confused. He was hyper-religious and prayed continually. After three days he became assaultive, negativistic, and resistive. He then quieted down and became apathetic, evasive, and cooperative. He was transferred after two months to the Metropolitan State Hospital with the diagnosis of dementia praecox - catatonic type, condition improved. Since 1934, he has stayed at this hospital and appears to be completely out of touch with reality although he is able to identify himself. He has been disinclined to answer questions and has required pack treatment during the intervals when he has become disturbed and assaultive. He has deteriorated considerably since his admission and now sits around the wards unoccupied.

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period when Joseph became mentally ill, she herself was becoming increasingly worried over her physical handicap and her inability to lead a normal life. She became exasperated to think that she could not even do housework. Gradually she developed hallucinations and at one time she told her mother that a young man had entered her room and assaulted her. She alsodreamt a great deal and became quite unable to differentiate between the dreams and reality. Also duri ng this period she began to worry about Joseph's condition and wondered if her own handicap might lead her to a similar state of mental illness.

As the hallucinations became more a part of her life, she was admitted to the Danvers State Hospital in 1935, when she was twenty-three years old. Basically, she was very childish and several times expressed a superficial desire to die. This desire is present to date. In 1936 she was transferred to the Metropolitan State Hospital as unimproved. While at this hospital she has been difficult to manage and has often been violent and suicidal. At first she required continual and close supervision. Recently she has been able to attend Occupation Therapy classes, and enjoys this as she can through this find something that she is able to do. She still suffers from hallucinations, and is somewhat paranoid toward other patients. She talks freely about herself and continues to worry about her physical condition.

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Although she would like to go home, she has sufficient insight and judgement to realize that this is impossible and reconciles herself to staying in the hospital. Her diagnosis since entering state hospitals has remained psychosis with epidemic encephalitis.

These two siblings are two years apart in their ages and throughout their childhood they were very close, playing together almost continually until Agnes became ill. They were both treated abusively by their parents, although Agnes received even more severe beatings as her physical condition irritated her parents who could not understand it. Neither Agnes nor Joseph became particularly adequate individuals, Agnes because of her physical handicap, and Joseph because of his unstable emotions. The family lived in an urban community and economically fell into the marginal group, which in itself suggests the possibility of a lack of security in the home. Both parents, too, were emotionally highstrung and given to beating their children as a corrective measure. From the time of her illness on, Agnes became more and more unstable, and as she grew up she brooded a great deal over her physical condition. Following Joseph's illness, she then added to her worries the possibility of becoming mentally ill herself. Her greatest fear of mental illness was that of being able to lead a less normal life than the one she already had. In the hospital the two have gone

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through similar illnesses, having periods when they were disturbed, but on the whole being quiet and cooperative. Joseph's mental deterioration is more marked than Agnes' as he showed more intelligence to start with, but both have deteriorated considerably during their long hospitalizations. Agnes, however, has maintained a good degree of insight and judgement, whereas Joseph is completely lacking in either. Neither has a hopeful prognosis.

The fourth case to be presented is that of Mary and Richard S, a brother and sister of Irish parents. The father of these young people was born in Ireland and came to this country thirty-five years ago. He is a quiet, almost mouse-like man, who has always been in good health and has been described as a social drinker. He works as a fireman, tending furnaces in the neighborhood of his home. The mother was also born in Ireland, in 1883, and is described as being a kind and good-natured woman, though somewhat domineering, especially in the case of her younger children. Occasionally she takes jobs outside of the home doing housework. The grandparents on both sides of the family died in Ireland of old age. There are eight siblings in this family, Mary and Richard being the youngest. The ages of the first six vary from thirty-six to twenty-five, and then in order is Mary, aged twenty-three, and Richard, aged twenty. The

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family lives in an urban section which is residential, and their income is marginal although several members of the family are employed. The family is devoutly Catholic. As far as is known there is no previous history of mental or nervous disease.

The first patient, Richard, was born in 1927, and was a normal, happy child. He enjoyed participating in sports with other boys of his own age up to the time when he was in the sixth or seventh grade, at which time he had tonsillitis followed by a rather severe hearing defect. Since that time, Richard has become seclusive and self-conscious, and seldom associated with anyone outside of his immediate family. Most of his leisure time was spent in the home reading of listening to the radio. He was described when about fourteen years old as being unstable and "queer" by his family, who also reported that he had temper outbursts on occasion. He left school in the twelfth year and worked at several jobs, finally working as a messenger boy in a telegraph office. After eight months at this he left as he felt that the boys with whom he was working were ridiculing him and making life difficult for him. After this he took a job for three months and then remained home, until his admission to the Metropolitan State Hospital five or six months later. Throughout his teens, Richard was known to have arguments with one or another of

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his siblings, and followed these he would refuse to speak to that sibling for four or five weeks. This sort of argument became more frequent in the home, with Richard usually being the instigator, and gradually he became nervous and run-down. He ate and slept poorly also. Then his seclusiveness, which had formerly shown itself only outside of the home, became evident within the home. He would shut himself in his room and frequently expressed the feeling that his family was against him. He habitually demanded his own way and was resentful of anyone who prevented him from having it. He was never an affectionate boy, and characteristically was hateful to anyone of whom he was not fond. His father several times became the object of this hatred for no apparent reason. Since his deafness, Richard has not associated with even his former boy companions, and he was never known to have had any interest in girls or to go out with them.

The second patient, Mary, was born in 1923 and was said to have had a normal childhood. She mixed normally with girls her own age but never kept company with boys. After leaving high school, before completing her course, she took several jobs and apparently did well in these. These jobs involved factory work of various sorts. Up until about a year prior to her admission, much of her leisure time was spent in the normal activities of a young

The second patient, Mary, was born in 1928 and was said to have had a normal childhood. She mixed normally with girls her own age but never kept company with boys. After leaving high school, before completing her course, she took several jobs and apparently did well in these. These jobs involved factory work of various sorts. Up until about a year prior to her admission, much of her leisure time was spent in the normal activities of a young

girl in a group of girls. Following that time, however, she gave up these associations and spent most of her time at home.

During the noticable onset of Richard's illness, Mary was in the home and observed that Richard felt people were following him which caused him to refuse to go to work, or even to go out of the house during the day. He would, however, go out a night and then, on arriving home, would lock all the doors and appear quite excited. He asked his mother to get a priest for him as he thought he was dying, but when the priest came Richard had pushed his bed against the door to his room so that no one could get in. During his episodes of excitement he thought that he smelled gas and felt that his mother was poisoning him. He also refused to eat at these times for fear of poisoning. He was then admitted to the Metropolitan State Hospital where, on admission, he appeared preoccupied, blocked, suspicious, and displayed mannerisms. He was careless about his personal appearance. Following his admission he was given a series of eighteen electric shock treatments which brought about no improvement in his condition. He was both auditorily and visually hallucinated, and occasionally showed brief, sudden outbursts of temper. He had ideas of reference and maintained his persecutory ideas. His behavior was silly and his conduct entirely bizarre. He demonstrated flexibilitas cerea and was diagnosed as dementia praecox -

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Following the onset of Richard's illness and the early part of his hospitalization, both of which she had witnessed, Mary began to feel that there was something at the telegraph office that had made Richard mentally ill. Consequently, she got herself a job there as a teletype operator in order to discover the cause of his illness. She did her work there satisfactorily, but soon became somewhat disturbed and began to feel that much of the electricity in the office was being directed toward her. She felt that she herself had become a receiving set, and that she was receiving messages at all times of the day and night. Gradually the family noticed that her behavior was changing and felt that she was becoming mentally ill asRichard had. She became disturbed over the banging of a new boiler in the house and felt that the neighbors were responsible for the noise and were trying to make her family vacate their half of the house. She made up all sorts of explanations for this noise and refused to listen to rational ones. One morning just prior to her admission to the Metropolitan State Hospital, Mary took a knife from the table and pointed it at her heart saying that she would rather die than listen to that noise any longer. On admission

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to the hospital, Mary displayed a definite sexual preoccupation. Her affect was flattened and at times she was very silly. She continued to feel that she was a receiving set and explained it by saying that she had radium in her ears. She had vague delusional systems and many paranoid ideas. She was diagnosed as dementia praecox - type undetermined.

As children, Mary and Richard played together a good deal as they were the closest in age of the siblings. As they grew up, following Richard's deafness, Mary remained interested and solicitous of Richard, but he had little to do with her other than to instigate arguments and be mean to her. Mary witnessed the onset of Richard's illness as she was still living in the home, and was quite disturbed over it. She maintained sufficient interest in Richard to visit him regularly at the hospital and even to take a job in the firm for which he had been working, in order to find out why he became mentally ill. She felt that there was something about this firm which was conducive to mental illness, and her belief in this was so strong that she herself became ill while working there. In the hospital setting the two are a greatdeal alike although Mary is a little more willing to talk to strangers than Richard. When Richard was interviewed he refused to discuss anything that did not seem to him to be perfectly objective. Mary

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is willing, on the contrary, to converse on a more personal level, although throughout the interview the conversation was frequently interrupted by the messages she was receiving and thus, adequate responses were not forth-coming at all times. Mary is quite willing to admit her hallucinations and delusions and seems almost glad to have an opportunity to discuss them. To date she lacks insight although Richard seems to recognize the fact that he is not well. He rationalizes his illness, however, by saying that he was mentally well until he was given electric shock treatments. Mary says that there is the physical agent of electricity in her body, but Richard feels that his trouble lies in his mind. In the hospital, the two have little to do with each other, although Mary is willing and anxious to see Richard. She continues to be concerned over his condition, but he shows no interest whatsoever in hers. Richard has improved sufficiently to go home on overnight visits, but Mary is still too ill to be allowed out of the hospital for the time being. Even Richard is not mentally well at this time.

The last case to be presented in this chapter is that of the R sisters, Dorothy and Grace. The father of these girls was born in the French West Indies about 1889. He worked in this country as a long-shoreman, earning $2.00

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to $2.50 daily, and also did laborer's work on occasion. He never assumed any responsibility for the support of his family and frequently deserted. He was arrested on twenty-nine occasions from 1915-1934 for drunkenness and once for assault and battery. He was brutal when under the influence of alcohol and would beat both the mother and the infant girls. It was believed that he attempted incest with the older of the two, Dorothy, when she was sixteen years of age. The mother was born somewhere in the south of poor negro parents. She was considered to be a good mother who had nice manners and who did all she could for the girls. She, however, died in 1911 at the age of twenty-two after a month's illness with pulmonary tuberculosis, leaving the children in the father's care. There is no known history of mental illness in this family, but the mother died of tuberculosis and the father was shiftless, irresponsible, and alcoholic.

The first of these sisters, Dorothy, was born in 1909 while her sister, Grace, was born in 1910. They were said to have been normal in their early development, although physically both were undernourished and had rickets. Following the girls' birth there were several separations of their parents. The mother then died, in 1911, when the girls were one and two years of age. The father immediately turned their care over to a maternal grandmother, with whom they

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lived for three years. At that time this grandmother died and the father was forced to assume the responsibility of their care. He then placed the children with a private family, when they were four and five years old, and agreed to pay their board. He failed to do this and although the boarding parents met him several times on the street and urged him at least to write or visit the children, he continued to ignore them or his obligations to them. Finally, in December of 1914, the children were taken by the Division of Child Guardianship and placed in a series of three foster homes which were considered to be good homes. The foster parents in each case showed an interest in the children. The Division was able to keep the girls together during the next important years so that they grew up together and were very close.

To study the individual girls more closely, we can see that throughout the foster home placements, Dorothy was always the stronger of the two and was more active and seemed to enjoy more playing with other children. Dorothy's disposition was said to be splendid and she was felt to be even-tempered and responsive. She was a well-behaved child. She did fairly well in school but was poor in arithmetic and had to repeat the third grade. As she grew up, however, Dorothy's personality was seen to undergo a change. She became indolent and careless in school although her conduct

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and attitude were good. Her concentration became increasingly poor. In 1918, when she was nine years old, she had influenza and following this did even more poorly in school. The next year she improved but in 1920 her work again was unsatisfactory and she was found to be dishonest and sly. She then went to summer school to make up her work and became neat and tidy in her appearance. By 1923, though, she appeared to be dull and stupid. She then had a tonsillectomy after which she was observed to be acting strangely and at times she was very seclusive and immobile. The foster parents felt that she was brooding over something but she was so uncommunicative that they could not get to the bottom of the difficulty. Then she became moody, refused to go to school, and had periods when she would laugh inappropriately.

As we have already noted, Grace grew up in the same foster homes as Dorothy and was also well-liked by the foster parents in these homes. Grace was observed to be a bright, interesting child. She liked school and did fairly good work there. Up until Grace was ten years old she periodically suffered from nocturnal enuresis. It was reported at this time that Dorothy was very kind to Grace and that there was a great deal of interdependence between the two girls. In 1917, when Grace was seven years old, she had a tonsillectomy, six years before Dorothy's operation. The following year she developed swollen glands but this

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condition eventually remedied itself. By 1918 Grace's school attendance had become irregular, but her grades continued to be very satisfactory.

By 1924, when the girls were fourteen and fifteen, Dorothy's behavior had begun to change so much that in December of that year, she was observed for ten days at the Boston Psychopathic Hospital. She was seclusive and underactive, and generally suspicious. At the end of her observation period she was discharged with the recommendation that she be placed in a more normal environment than that of the foster home in which she was living. She was diagnosed as dementia praecox. She was returned to the same foster home and after two months she was again observed to be acting peculiarly and she was sent for another observation period to the same hospital. At this time she had both auditory and visual hallucinations and was distractible. She would scream noisily at times and frequently called for her foster parents. She was confused about her previous admission and in March of 1925, she was transferred to the Worcester State Hospital with a diagnosis of dementia praecox - type undetermined. She was sixteen years old at this time. At this hospital her behavior remained essentially unchanged. Her intelligence was felt to be below average and emotionally she was childish and immature. For the next five years Dorothy remained at this hospital but

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several times she managed to escape. At such times she always contacted Grace so that this sister was thoroughly exposed to Dorothy's illness in all of its stages. While in the hospital Dorothy had recurrent periods of catatonic stuporous conditions.

Grace continued in foster homes, and as time went on she began to demonstrate behavior almost identical with Dorothy's at the time of the onset of her mental illness. She lost interest in everything, became seclusive, and was indifferent. She was listless in school and was unable to go on to take a commercial course in high school as she was failing in junior high school. In 1927, when she was seventeen, Grace was placed in a domestic situation but was not felt to be sufficiently responsible to care for the young children in the home and was, therefore discharged. In June of 1928 she was seen to be silly and laughing without provacation. She was preoccupied and acted as if she were in a dream. She became restless, slept very little, and finally left her employer. She was observed at the Boston Psychopathic Hospital and was diagnosed as manic depressive psychosis - manic type, and was then transferred to the Worcester State Hospital where the diagnosis was changed to dementia praecox - hebephrenic type. She reacted to auditory hallucinations, made several attempts to run away, but on the whole was apathetic in attitude.

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In 1931, when the girls were twenty-one and twenty-two years old, they were both transferred to the Metropolitan State Hospital where they have almost identical hospital courses, being stuporous and confused at times and excited, violent, and impulsive at other times. Throughout they were jealous of one another, both would run away if given the slightest opportunity, and in general they behaved very similarly. During their disturbed periods both would be untidy in their personal appearance, while they would be neat and tidy at other times. When out of the hospital, both girls would associate with men of questionable character. Both are childish and immature and continue to be very much dependent on one another. When together for any length of time they always argue quite bitterly, but when apart will do anything in order to get together. Both take advantage of kindnesses and tend to give up easily. The two are described as being affectionate and generous to each other and concerned about each other's health, although when in each other's company their jealousies come out into the open. Dorothy was given twelve trials in the community in the same domestic situation over a period of seventeen years. The family for which she was working took a great deal of interest in her and gave her every chance to succeed, but after working for awhile, Dorothy would decide that she needed a change of position and would leave. She has gone

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through a similar episode as recently as a few months ago in another position. This time she wanted to change from domestic work in a nursing home to a factory where she felt that she would not be so overworked.

Grace's onset of mental illness, on the other hand, was seen to have come a few years after Dorothy was admitted to state hospitals. During the intervening period, Grace had visited Dorothy at the hospital and had seen her on the occasions when Dorothy had escaped from the hospital. All of this troubled Grace as the two sisters were very close emotionally, and she eventually developed almost identical mental symptoms and required a period of observation, followed by commitment, herself. Both girls are able to adjust well in the community for brief periods of time, but after a while they begin to get bored at one job and wish to change to something else. Both girls had a final diagnosis of dementia praecox - catatonic type, and at the present time both are adjusting fairly well in the community although their old difficulties present themselves from time to time.

CHAPTER VI

Case Histories II

Thus far we have studied five pairs of siblings: one pair of twin brothers, two pairs of sisters, and two mixed pairs. The diagnoses of these ten cases were broken down as follows: nine cases of dementia praecox; five of which were of the catatonic type, two of the hebephrenic type, and the remaining two of type undetermined; and one case of psychosis with epidemic encephalitis. In the case of the twin brothers both were diagnosed as dementia praecox with one being of the catatonic type and the other type undetermined. The two pairs of sisters were diagnosed as dementia praecox, one pair being of the catatonic type and the other of the hebephrenic type. In the mixed pairs, both males were diagnosed as dementia praecox of the catatonic type while one of the females was dementia praecox - type undetermined and the other was diagnosed as psychosis with epidemic encephalitis (with many symptoms resembling dementia praecox).

In four out of the five pairs there was a three years' difference in the age at the time of the onset between the first and the second patient, and in the fifth case, both patients were the same age. In each case

CHAPTER VI

Case Histories II

chronologically the second patient became mentally ill shortly after the first, and in each case there was a close emotional relationship between the two siblings. The average age of these five pairs of siblings at the time of their first hospital admission was twenty-three years.

In the fifteen remaining pairs to be discussed briefly in this chapter, there are seven pairs of sisters, three pairs of brothers,and five mixed pairs. The average age at the time of the first hospital admission of these thirty siblings was thirty years. Of the thirty patients in this group there are twenty-four with the diagnosis of dementia praecox, there being eleven of the catatonic type, seven of the paranoid type, three of the hebephrenic type, one of the simple type, and two type undetermined. There is one case of paranoia and paranoid conditions, one involutional psychosis - paranoid type, two with psychosis with mental deficiency - moron, and two with manic depressive psychosis - manic type.

To show these diagnoses now according to the individual pairs we find the following: of the sisters the first pair were both dementia praecox, one being of the catatonic type and the other of the paranoid type: the second and third pairs were all dementia praecox, one in each case being of the paranoid and the other being of the

hebephrenic type; the fourth and seventh pairs both have one sister with the diagnosis of dementia praecox - catatonic type and the other as manic depressive psychosis - manic type: the fifth pair has both with dementia praecox, one being of the catatonic and the other of the hebephrenic type: and lastly, the sixth pair has one with dementia praecox - type undetermined and the other involutional psychosis - paranoid type.

Of the brothers, the first and third pairs each have one brother diagnosed as psychosis with mental deficiency - moron, while the second brothers are both dementia praecox with one of the catatonic and the other of the paranoid type. The second pair of brothers is made up of dementia praecox, one being of the simple and the other of the paranoid type.

Of the mixed pairs, all of these pairs are made up of siblings with dementia praecox. The first, second, and fourth have one of the catatonic type and the other of the paranoid type. The third pair is made up of one type undetermined and the other of the catatonic type. The fifth pair has both of the catatonic type.

Let us turn now for a brief look at the education and marital status of these thirty patients to see if there is any noticable conclusion to be drawn from the factual

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Let us turn now for a brief look at the education and marital status of these thirty patients to see if there is any noticable conclusion to be drawn from the factual

data. First of all let us consider the seven pairs of sisters. Of the first pair, one sister went through grammar school (the first eight grades of school), worked unsteadily at unskilled jobs until her illness, and remained single. The second sister in this pair went through the second year of high school, worked as an office girl and then as a salesgirl. She married but had no children. Of the second pair, both sisters went through grammar school, and both remained single, working as stenographer and bookkeeper respectively. Of the third pair, again both sisters went through grammar school, and on leaving school were employed as factory workers. Both married and one sister had one child while the other had none. The fourth pair had one sister who went through the seventh grade and the other who went through high school. The former worked as a housekeeper following the death of her husband, and the latter was a factory worker. She divorced her husband. Both women had one child. Of the fifth pair, one went through grammar school and the other through only the seventh grade, but after school both worked as factory workers. Each married, one happily and the other unhappily, and each had three children. The sixth pair consisted of negro sisters with a very poor background. Both went into high school and trade school, and then one worked as a factory worker while the other did domestic work. Both sisters divorced their husbands, the first having had one

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and the second having had six children. Following their separations, both became promiscuous and had an illegitimate child. Lastly, the seventh pair consists of two sisters, both of whom went through grammar school. The first had no occupation and the other became a salesgirl. Both married and one had six children while the other had one.

As can be easily seen, the sisters as a rule had about the same amount of education, did similar types of work, and in many cases the outward pattern of sexual adjustment was the same, e.g., in those cases were both married, there was usually the same number of children. Divorce and ensuing promiscuity ran in one pair, and another pair remained single.

Of the pairs of brothers, all six men remained single. Of the first pair, one brother went to school until he was fifteen years of age but was always kept in special classes because of his limited mental capacity. He has done a variety of laboring jobs. His brother went through the seventh grade of school and then left to become a mill-worker. The second pair is made up of brothers of superior intelligence. Both graduated from a well-known New England college, one studying for the ministry and the other for a musical career. Both became mentally ill before they had a chance to utilize their learning and skills. The third pair had one brother who went through the sixth

grade and became a drifter in his work, while the other went through grammar school after repeating at least two grades, and has been employed as an unskilled laborer. Here again it is possible to see a similarity in the amount of education and the type of work done by the members of each pair. As mentioned before, also, none of the men ever married.

Of the mixed pairs, we find that in the first pair the brother went through the ninth grade, receiving fairly good grades. On leaving school he was set up by his brothers in a shoe repairing shop. He married unsuccessfully, and there were four children from this marriage. His sister went through the fifth grade in Italy and then went to night school in this country for two years while she did dressmaking during the day. She also had an unsuccessful marriage which ended in a separation. There were no children from this marriage. In the second pair, the male went through one year of high school and became mentally ill before he had a chance to enter any occupation. His sister went through grammar and business school and then worked as a cashier and waitress in restaurants in Boston. She had a very unhappy marriage and two children. The brother in the third pair graduated from grammar school after repeating the first, second, and fourth grades. He then went into trade school where he did poorly and finally was

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expelled. He then joined the Army where he had four AWOLs followed by a court martial and dishonorable discharge. His sister went through high school and then for six months to a business school, following which she became a machine operator in a factory. Following her discharge from the hospital she married happily and had one child. The fourth brother went through two years of high school and held a number of government jobs during the war as inspector. He took a job as a truck driver when his first mental symptoms appeared prior to his admission to the state hospital. He is happily married and has one child. His sister, on the other hand, went through high school and then did laundry and stenographic work. She married happily and had three children. The last brother went through high school and was very ambitious to go on to study journalism. In order to continue his education he worked days and went to school at night. He remained single. His sister went through high school and then worked as a mill worker. She married happily and had five children.

Here again it is possible to see a similarity in the amount of education and occupational levels of the members of each pair. The sexual adjustments also run along quite similarly. With the exception of the two brothers who went through college, all of these thirty individuals came

from the marginal economic group and only eleven were able to reach high school. All thirty came from an urban environment.

Let us now review the emotional interaction between the individual siblings as we have been able to see it in the case records themselves or from interviews with the patients. Of the sisters there seems to be a very definite emotional relationship between the sisters in five of the pairs and a question of the sixth pair, with only one pair in which there was no interaction between the two siblings for several years prior to the onset of the first sibling's mental illness. In the first case in which both have dementia praecox, one hebephrenic and the other paranoid, prior to their hospitalization as well as during it, the first continually lauded her successes over the other. In the hospitals she was always cruel to this sister so that finally one was transferred to another hospital in order to separate the two. In the second pair we have two more cases of dementia praecox, who like the first pair had one sister of the hebephrenic and the other of the paranoid type. These sisters were together when the first became ill and the second visited her regularly in the hospital, finally becoming ill herself one day when she was taking the first for a visit from the hospital. In the third pair we have one case of involutional psychosis - paranoid type and one

dementia praecox - type undetermined. Since the first became mentally ill, the two have been closer emotionally than at any time since their childhood. The second sibling was very much disturbed over the illness of her sister and tended to brood over the possibility of becoming mentally ill herself. The fourth pair included one case of manic depressive psychosis - manic type and one case of manic depressive psychosis - depressive type which was changed to dementia praecox - catatonic type. The second patient had been mentally ill as a young girl, but as the two lived apart since their childhood with only occasional visits to each other, there was little interaction at that time. However, the second patient visited the first just prior to her own illness and when she found that this sister had been in a state hospital she worried to a point where she herself became ill and required hospitalization. In the fifth pair we have one sister with dementia praecox - catatonic type and a second sister with manic depressive psychosis - manic type. For years the second patient had nothing to do with the first and refused to visit her at the state hospital or to hear anything about her, possibly indicating a fear that she might herself become mentally ill. In the sixth pair we have two more cases of dementia praecox, one of the catatonic type and the other of the hebephrenic type. These girls have gone through many recurrent episodes and in each case they

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have been in the company of the other during the onset of their illnesses. Both have gone through similar lives, having been divorced and each having had an illegitimate child following her separating from her husband. Also following their separations they would return to their original home to live. They have remained for years dependent on one another. In the last pair we again have two sisters with dementia praecox, one of the catatonic and the other of the paranoid type. These sisters are sixteen years apart in age and up to the time the first sister became mentally ill, they saw little of each other. At that time, however, the younger became psychotic following the birth of her first child, and the older sister cared for this child until her sister came out of the hospital the first time. During that period the sisters were very close and the older sister witnessed the onset of her sister's second episode. The second patient herself feels that this had a great deal to do with her own illness.

Let us now turn to the three pairs of brothers. In each case there seems to be no interdependent relationship at any time within five years of the time of onset. It is interesting to note, however, that in the case of the brothers of superior intelligence, that although there was no interaction between the two boys, there

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was a great deal of dependence in each case upon the mother who has been described as mildly psychotic herself. Each brother tried to do outstanding work in college and in his graduate work in an effort to please his mother and to honor his late father. Neither, however, could stand the strain and eventually each became mentally ill.

Lastly, let us consider the mixed pairs. In one pair there seems to be a very definite emotional relationship, in two cases there is a question of the two having had anything to do with each other, and in the last two pairs it was felt that there was no existing interaction between the two. In the case in which the interaction was definitely affirmative both siblings were diagnosed as dementia praecox - catatonic type. In the cases where there is a question, in one pair both were dementia praecox, one of the catatonic and the other of the paranoid type. The other pair had one dementia praecox - catatonic type and one paranoia and paranoid conditions. In the two pairs in which there was felt to be no interaction, all were dementia praecox, one pair having one of the paranoid and one of the catatnoic types, and the other pair having one of the catatonic type and the other type undetermined.

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CHAPTER VII

Summary and Conclusions

One of the outstanding differences to be noted in the comparison of the males and females is the difference in the age of the patient at the time of the onset of mental illness. The average for the males is 23¼ years while that of the females is 29½ years. Also very noticable is the fact that of the cases studied the majority had diagnosis of dementia praecox, and of the dementia praecox cases the majority were of the catatonic type.

In many of the cases in which we know something of both the mother and the father, we find that the father is a weak, mild-mannered, man, while the mother is a domineering woman who runs the family with an iron hand. In the majority of cases also the two patients who have become ill in one family are fairly close together in age, and the second illness usually follows the first fairly shortly. Similarly, the ages of the siblings in each pair studied, frequently are within a few years of each other at the time of the onsets of mental illness. In several cases the second patient was emotional to start with and if the two siblings were in contact, the first's illness made a deep impression

CHAPTER VII

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on the second, frequently causing the second to brood and worry until he himself became mentally ill. In our only case of twins, we see that there was a continual interaction between the two with the mother playing one against the other in a never-ending form of competition. The fact that they were twins alone was sufficient to bring about a certain degree of identification and the feeling that what happened to one twin would eventually happen to the other, and indeed, throughout their various illnesses, the second followed the first after a short period.

In over half of the cases seen in this study it is interesting to note that it is felt that there was a definite and often strong emotional interaction between the two siblings in a pair. This interaction was seen to have carried over from the time the two were youngsters and up until the time the first patient became mentally ill. In many cases it continued past this time with the second patient making visits to the hospital to see the first patient. In a number of the cases the two siblings were living together or near one another during the early stages of the first's mental illness.

It should also be noted that many of the illnesses are similar in nature, with essentially many of the same symptoms. Also, many of them are of similar duration. In

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the case of those individuals who have been in our hospital since its opening, many were transferred from other hospitals where they had been for some time prior to their transfer, so that a good number of the patients have been mentally ill and hospitalized over a period of at least fifteen or twenty years. Some of these patients are eventually able to leave the hospital and to make a good adjustment in the community, but the older of these patients seldom improve mentally enough to be tried in the community on visit. Another drawback for these latter patients is the fact that as they get older, their families and friends lose contact with them or die and there is seldom anyone left who is willing or able to care for them. Many of these patients have had no visitors over a period of years, and as the case with many such patients, there is no longer any strong incentive to get well so that few recoveries actually do take place.

As I have mentioned before, all of the siblings under study here have come from urban environments, and the bulk have been considered to be of marginal economic status. Several of the patients who became ill while fairly young were single and living at home. The majority of the women patients were married, but several of these marriages were described as being unhappy affairs, quite irrespective of children in the family. The majority of the men, on the

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other hand, were unmarried, and a few had not even kept company with girls but had preferred the company of their own sex. Only three of these males admitted ever having had heterosexual relationships.

Many of the siblings were unstable individuals for many years prior to their actual attacks of mental illness, and many more came from homes in which there was parental instability. To add to this instability was the economic and social insecurity mentioned above, all of which factors influenced the siblings strongly at a later date. In a few of the cases there were also other members of the family with physical or mental handicaps which made a normal life more difficult, and in several of the homes, the parents were born abroad while the children were born and brought up in this country. That in and of itself brings about a certain amount of friction in the home which may prove disasterous to a sensitive individual.

On the whole, then, this study has shown that of the siblings studied, the economic and social standards of the families and individuals were low. There was little real security in the home. And, most important of all, there seems to have been a good deal of emotional interaction between the individual siblings in the twenty pairs, during childhood and/or in later life around the time of the onset

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of the first sibling's mental illness. The ages seem to be similar as to the diagnoses in a large number of the cases. Although many are seen to be different types of dementia praecox, the bulk are both dementia praecox.

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APPENDIX

Schedule for Thesis

Name of patient Case Number

Age at time of onset

Duration of onset prior to admission

Name of hospital

Date of hospitalization

Date of discharge from hospital Diagnosis

Education I.Q. (when available)

I. Family History

Personal History including that leading up to onset

Hospital Course

II. Marital status

Social status

Economic status

Occupation

Summary:

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